

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

164038

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN GARDNER MURRAY BARTLETT</b>				2a. DATE OF DEATH MONTH <b>6</b>	MONTH <b>6</b>	DAY <b>85</b>	YEAR <b>12:30AM</b>				
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>2</b>	DAY <b>18</b>	YEAR <b>28</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	IF UNDER 24 HRS. MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <b>XX</b>	NEVER MARRIED <b>□</b>	WIDOWED <b>□</b>	DIVORCED <b>□</b>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b>					
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 4 Box 220, Easton</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Broker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>				
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>Rt. 4 Box 220/ 21601</b>					
14. FATHER'S NAME FIRST <b>Francis</b>	MIDDLE <b>Gilpin</b>	LAST <b>Bartlett</b>	FIRST <b>Ruth</b>	MIDDLE	LAST <b>Murray</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>YES</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1951-52</b>	17. INFORMANT <b>Cynthia E. Bartlett see 13e.</b>	ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FATAL ARRHYTHMIA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 m 20 s</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial INFARCTION</b> <i>Passed</i> APPROXIMATE BETWEEN ONSET AND DEATH <b>1 m 20 s</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this physician) attended the deceased from <b>4-3</b> , 19 <b>85</b> , to <b>6-6</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>5-1</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen P. Carney</i>				DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>6/6/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>				22e. ADDRESS <b>Dutchman's Lane, Easton, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>	23b. DATE <b>6-6-85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Delmarva Crematory</b>	23d. LOCATION CITY OR TOWN <b>Lewes</b>	23e. COUNTY <b>Sussex</b>	23f. STATE <b>Del.</b>						
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>	25a. DATE REC'D. BY REGISTRAR <b>JUN 10 1985</b>	25b. REGISTRAR'S SIGNATURE <i>John J. DeLaney</i>									
25c. ADDRESS <b>Easton, Md.</b>											

200501



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

65 13140

165072

REG. NO.

1 -  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			HARRY	T.	BARTON	6	10	85	4:10 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
male		caucasian		3	3	14	71				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA				Talbot					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Tilghman		Main St., Tilghman, Md.				Cashier		Banking			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Talbot		Tilghman		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Main St./21671			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Harry		T.		Barton, Sr.		Bessie				Ewing	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		P.O. Box 204			
NO		216-05-6847		M. Elizabeth Barton		Tilghman, Md. 21671					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF PROSTATE</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (we) attended the deceased from <u>6-13</u> 19 <u>84</u> to <u>6-10</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>5-25</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <u>Stephen P. Carney</u>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				22c. DATE SIGNED <u>6-10-85</u>					
Stephen P. Carney, M.D.		Dutchman's Lane, Easton, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE	
Burial		6-12-85		Woodlawn Memorial		Easton		Talbot		Md.	
24 FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home		Easton, Md.				JUN 12 1985		<u>Wardson Pendell</u>			

General

80% COTTON, 15% EGG



208106

184029

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

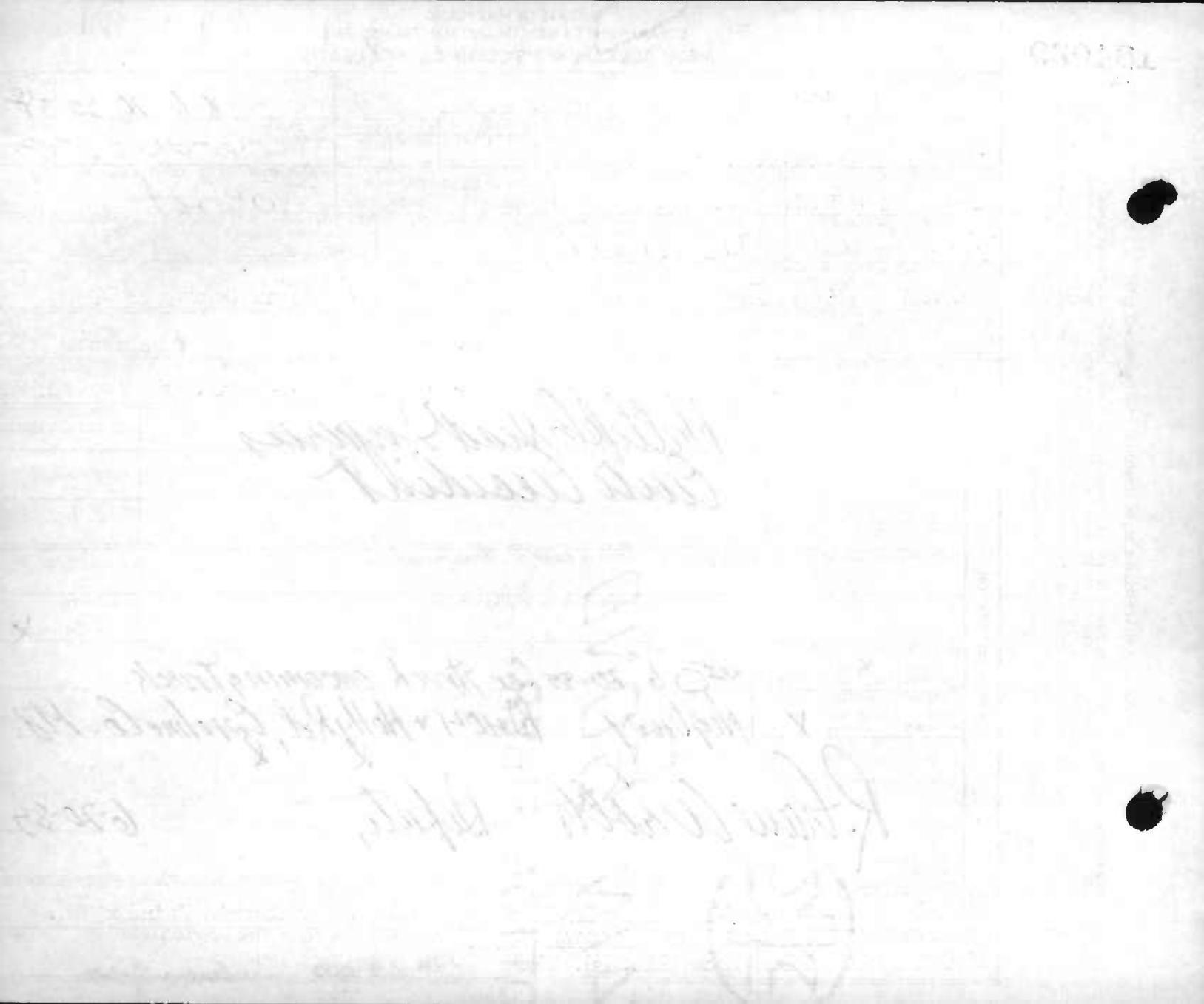
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM EM-3. RETAIN AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1814 |

1- STATE REGISTRAR		REG. NO.															
I. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE KNOWN DEATH OCCURRED		MONTH	DAY	YEAR	2b. HOUR M.		
arlene s. Bleuer										6 20 1985		3:10			3:10 M.		
3. SEX	4 RACE	5. DATE OF BIRTH MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR M.			
Female	White	Feb.	4	1947	38 yrs.				6-20-85		1985	5:21		5:21 M.			
7b. CITIZEN OF WHAT COUNTRY?		7b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Talbot					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Revere										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14 LeHavre Court, 20854		12b. KIND OF BUSINESS OR INDUSTRY Home							
14. FATHER'S NAME FIRST Benjamin		MIDDLE		LAST Miller		15. MOTHER'S MAIDEN NAME FIRST Evelyn		16. INFORMANT Michael Blum, 14 LeHavre Court, Potomac, Md.		ADDRESS 20854							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-46-9741		18. CAUSE OF DEATH (Enter only one cause per line for item 18a) PART 1 DEATH WAS CAUSED BY: 8129 IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Helen had injuries Auto Accident. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> 3:00 P.M. MONTH <input checked="" type="checkbox"/> 6 DAY <input checked="" type="checkbox"/> 20 YEAR <input checked="" type="checkbox"/> 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19 OR PART 2) Car struck oncoming truck.		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway		21f. LOCATION STREET 1170 Rockville Pike, Rockville, Md. 20852		21g. COUNTY Fairfax		
22a. I certify that I am in charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE R. Blane Carroll		TITLE (SPECIFY) M.D.										MEDICAL EXAMINER R. Blane Carroll					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										DATE SIGNED 6-20-85					
23a. BURIAL, CREMATION, REMOVAL Buriel		23b. DATE 6/23/85		23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Gdn.		23d. LOCATION CITY OR TOWN Falls Church, Fairfax, Va.		23e. COUNTY Fairfax					23f. STATE Va.				
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHPLS. 1170 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR JUN 24 1985		25b. REGISTRAR'S SIGNATURE Julia David													

DPHMH - 17  
(VR A15 ME (5))  
20M 4/B2



178013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it with the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked as "Yes" show any injury, or other traumatic event, the medical examiner

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 18142

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Anna			C	Bouldin		June	21	85	3:00		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
female		Black	MONTH	DAY	YEAR	67	YRS.	IF UNDER 24 HRS			
8. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		U.S.A.						Talbot			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Easton Memorial Hospital									
13. STATE		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Md.		Edgewater			YES <input type="checkbox"/> NO <input type="checkbox"/>			141 Box 242 21638			
14. FATHER'S NAME FIRST		MIDDLE	15. MOTHER'S MAIDEN NAME								
Krause			Walmer			Hilander			Wancil		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR & DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
N/A		216-18-9608			Carlton Bouldin						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Undifferentiated</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS CONSEQUENCE OF b) <u>Abdominal Carcinoma (Primary) 3 mo</u>											
DUE TO, OR AS A CONSEQUENCE OF c) <u>Undetermined</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
19a.							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21a.											
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>June 20 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					APR 25			June 21 1985		STATE	
22b. SIGNATURE <u>P. Gregg Rhodes</u>					DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George H. Daniel</u>					22e. ADDRESS MD						
23a. BURIAL, Cremation (check one) (SPECIFY)		23b. DATE 6-25-1985		23c. NAME OF CEMETERY OR CREMATORIAL Robinson			23d. LOCATION Towson		COUNTY		STATE
24. FUNERAL DIRECTOR NAME <u>George H. Daniel</u>		ADDRESS Easton Md.						25a. DATE REC'D. BY REGISTRAR JUN 24 1985		25b. REGISTRAR'S SIGNATURE <u>Rita Davidson Pendleton</u>	

3

170043

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						5 18143			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Lloyd Robert Davis						5-31-85					11P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		WHITE		4 29 1920		65		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
USA-PA.		USA						Talbot				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton		Allevan Hospital						TEACHING		EDUCATION		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
MD		TALBOT		EASTON		YES <input checked="" type="checkbox"/>		417 TRIPPE AVE EL21601				
14. FATHER'S NAME		MIDDLE		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
FRITZ ALAN		DAVIS		MARCELLA		428108690		PATRICIA A. DAVIS		EASTON MD.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
YES		42 to 45										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Metastases</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lung</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) (this hospital) attended the deceased from <u>5/31</u> , 19 <u>85</u> , to <u>5/31</u> , 19 <u>85</u> , that (1) (we) lost sow the deceased alive on <u>5/31</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did <input checked="" type="checkbox"/> did not <input type="checkbox"/> view the body after death.												
22b. SIGNATURE W M H Wood		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W M H Wood		22e. ADDRESS EASTON, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 6/1/85		23c. NAME OF CEMETERY OR CREMATORIAL Delaware Crematory		23d. LOCATION CITY OR TOWN LEWES		COUNTY SUSSEX		STATE DE.		
24. FUNERAL DIRECTOR NAME Audrey P. Moore		ADDRESS Dentac, MD.		25a. DATE REC'D. BY REGISTRAR UN 1:10 AM		25b. REGISTRAR'S SIGNATURE Julie Darden-Pattelle						

60081

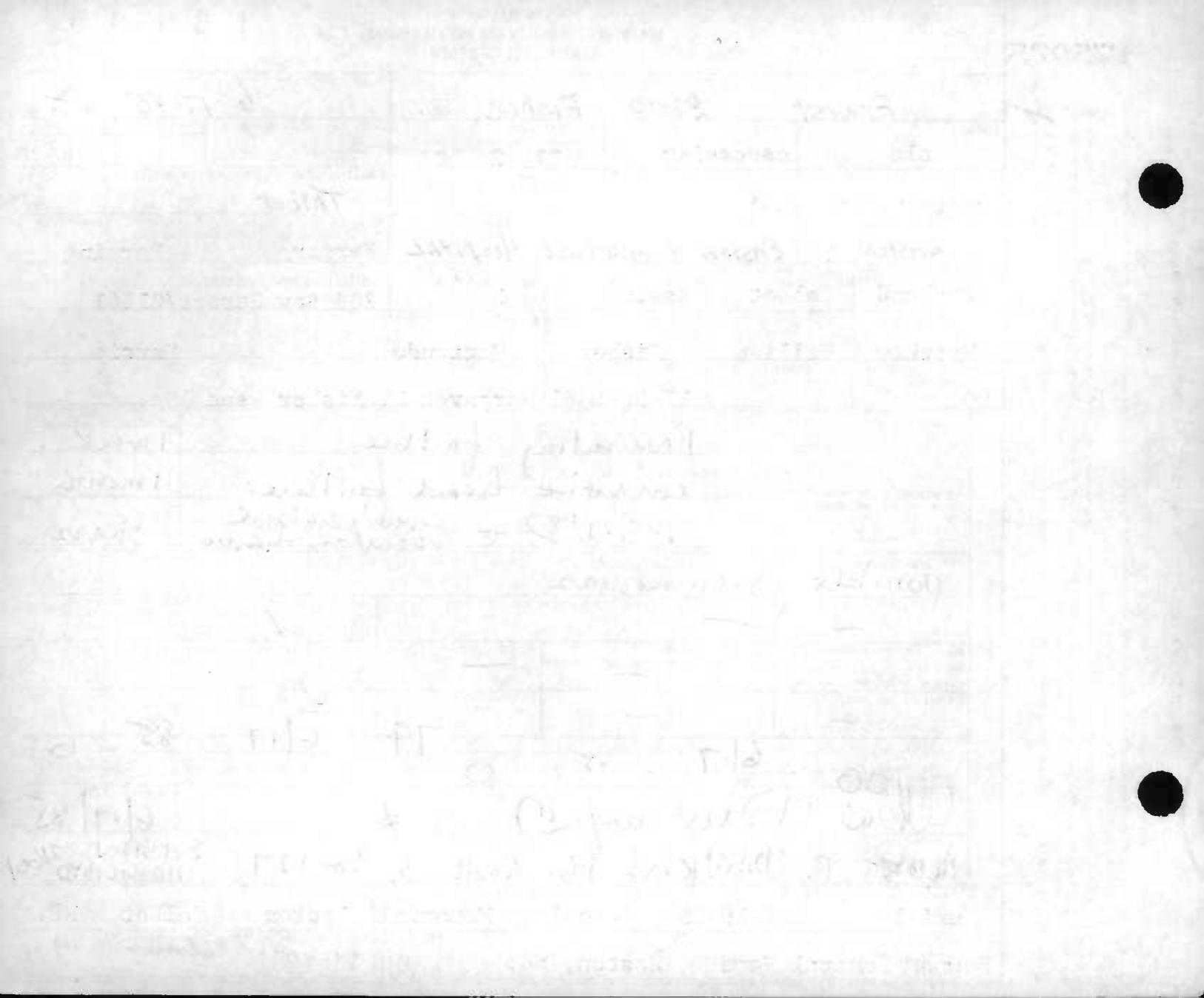
175025 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 (Cause of death), the physician or other traumatic event, the medical certificate should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5	1	8	1	4	4
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	6:30 AM
Ernest			EDWARD			Fisher SR.			6-17-85						
3. SEX	Male		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
			caucasian		11 2 08			76		YRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Pennsylvania		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
EASTON		USA		EASTON MEMORIAL HOSPITAL			Talbot								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
EASTON		EASTON MEMORIAL HOSPITAL								Farmer		Farming			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		206 Bay Street/21601				
Maryland		Talbot		Easton											
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S M AIDEN NAME FIRST		MIDDLE		LAST				
Matthew		William		Fisher			Gertrude				Harris				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS									
NO		217-36-0861		Margaret E. Fisher see 13e.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										1 week.					
Respiratory failure															
DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure										1 month.					
DUE TO, OR AS A CONSEQUENCE OF (c) PSD - cerebral vascular disease										years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
-										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from		19 85		19 85		79		6/17		19 85					
saw the deceased alive on 6/17		19 85		19 85		19 85		6/17		19 85					
I (we) did (did not) view the body after death.															
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22e. DATE SIGNED			
Albert T. Dawkins Jr.		ROUTE 3, Box 127		MD.								6/17/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial		6-19-85		Woodlawn Memorial		Easton		Talbot		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Newnam Funeral Home		Easton, Md.		JUN 19 1985		Sister Carlson									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached (or) issued the burial permit. Then please remove carbon paper, pages 3 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or either traumatic event, the medical examiner should be notified at once.

178011

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 18145

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
LORETTA F						Green	6-11-85				12 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Female		Black		MONTH	DAY	YEAR	MONTHS	YEARS	MONTHS	YEARS	HOURS	MIN.			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Talbot		U.S.A.					Talbot								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
EASTON				Memorial Hosp. Talbot											
13a. USUAL RESIDENCE (IF IN HOSPITAL, NURSING HOME OR OTHER INSTITUTION)				13b. GIVE RESIDENCE BEFORE ADMISSION				13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Md.				Talbot				YES <input type="checkbox"/> NO <input type="checkbox"/>		4160 25321625					
14. FATHER'S NAME				MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS						
George					Murphy	Cassie			Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
N/A				214-28-1308			Ernestine Wilson			4 hrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
DUE TO, OR AS A CONSEQUENCE OF (b) <u>THROMBOSIS OF RT INT CAROTID ART</u> 3 DAYS															
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEVERE ARTERIOSCLEROSIS</u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. The deceased died on _____, 19_____, and (I) (we) did not view the body after death.															
22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED							
22e. PHYSICIAN'S NAME, TITLE OR HAROLD E. BRYER, MD		22f. ADDRESS			22g. ADDRESS			6.11.85							
23a. BURIAL, Cremation, Removal (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY						
Burial		6-15-85		Newton			Carolina TA								
24. FUNERAL DIRECTOR NAME		TITLE		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Dug H. War		W.D. & Co. Inc.		JUN 24 1985			John Davidson Pendleton								

728017

171041

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 1 8 4 6

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR				
EDWARD NAB HARRISON						5	30	85	8 54 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
Male		Cauc.		MONTH DAY YEAR			72			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		U.S.A.		June 24, 1912			Talbot							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
EASTON, Md		EASTON MEMORIAL HOSP.		Md. State Highway Admin.										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland		Talbot		St. Michaels			Is <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Marengo St. 21663				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST							
Edmond Harrison				Nora Lomax										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
No		220-26-2081		Kay H. Howeth			Calvert St.							
							St. Michaels, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Verrucular Septal Pustule			21663			ADDRESS BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Acute Myocardial Infarction			4 hrs									
		(c) ASHD			5 days									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Seven Depression														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/30/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death		5/29/85			5/30/85									
22b. SIGNATURE W.M. H. Wood		DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/31/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.M. H. Wood		22e. ADDRESS EASTON, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE June 3, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Olivet Cemetery			23d. LOCATION CITY OR TOWN St. Michaels, Talbot, Md.			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Harmon E. Leonard, St. Michaels, Md.		ADDRESS 101 W. Preston St., Baltimore, Md.			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE R. R. Rendell									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report made.

120

1S3004

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 1 4 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
John W. Hurlock						6 29 85				5:25 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
Male		White		September 3, 1909		75					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			
Federalsburg, Md.		U.S.A.				Talbot County		Easton			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Easton Memorial				Salesman - Hardware Store							
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE					
Maryland		Caroline		Federalsburg		118 S. Main Street 21632					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
John Hurlock			Sarah Calloway								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			215-26-5042			Priscilla Pierce, 310 W. Central Ave., Md.			Federalsburg		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH D. If no cerebral arrest, months											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>D. If no cerebral arrest, months</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 29 CITY OR TOWN 85 COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive _____, 19____, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>Dr. James L. Lewis Jr. MD</i>			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6-30-85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			July 3, 1985			Hillcrest Cemetery			Federalsburg, Caroline, Maryland		
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.			ADDRESS Federalsburg			25a. DATE REC'D. BY REGISTRAR JUL 6 1985			25b. REGISTRAR'S SIGNATURE <i>Jane L. Lewis</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified or death.



REG. NO.

8 1 4 8

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be filed with the state health department within 24 hours after death, judge or may be

TC FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and certified, filed in by the funeral director, page 3 should be detached for use as a burial/transit permit. Then please remove carbon copies. Page 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 2 is marked or if Item 18 shows any injury, or other traumatic event, the medical professional who is treating the patient should be notified of this.

## TO HOSPITAL OR ATTENDING PHYSICIAN: The

1. DECEASED NAME (TYPE OR PRINT) <i>Margaret D. Jones</i>			2a DATE OF DEATH MONTH DAY YEAR <i>4-19-85</i>			3b HOUR 50 <i>4 PM</i>	
3. SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <i>April 7, 1903</i>		6 AGE (IN YEARS LAST BIRTHDAY) 82	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Oak Grove, Del.</i>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>	
10. CITY OR TOWN OF DEATH <i>Easton, Maryland</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Easton Memorial</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. School teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Public School</i>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Caroline</b>		13c CITY OR TOWN <b>Federalsburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Frank</b>		MIDDLE <b>Dickerson</b>		LAST		15. MOTHER'S MAIDEN NAME FIRST <b>Clara Ricketts</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-36-6715</b>		17. INFORMANT <b>Eloise G. Fitchett</b>		ADDRESS <b>Philadelphia, 19151</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>shock - hypotension</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>hypotension, renal failure</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>post percutaneous complications</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>arteriosclerotic cardiovascular disease, ante mortum</b>							
19a DATE OF OPERATION <b>6-16-85</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>perforated colon</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-16</b> , 19 <b>81</b> , to <b>6-19</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>6-19</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>R.B. Sanchez</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-21-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.B. Sanchez</b>		22e. ADDRESS <b>302 Commerce Dr Easton MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 27, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Federal Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Federalsburg, Caroline, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Frampton-Hawkins Funeral Home</b>		ADDRESS <b>Federalsburg, Md.</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Karen Pendleton</i>	

551921

Want to make  
a new  
one

1S3011

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

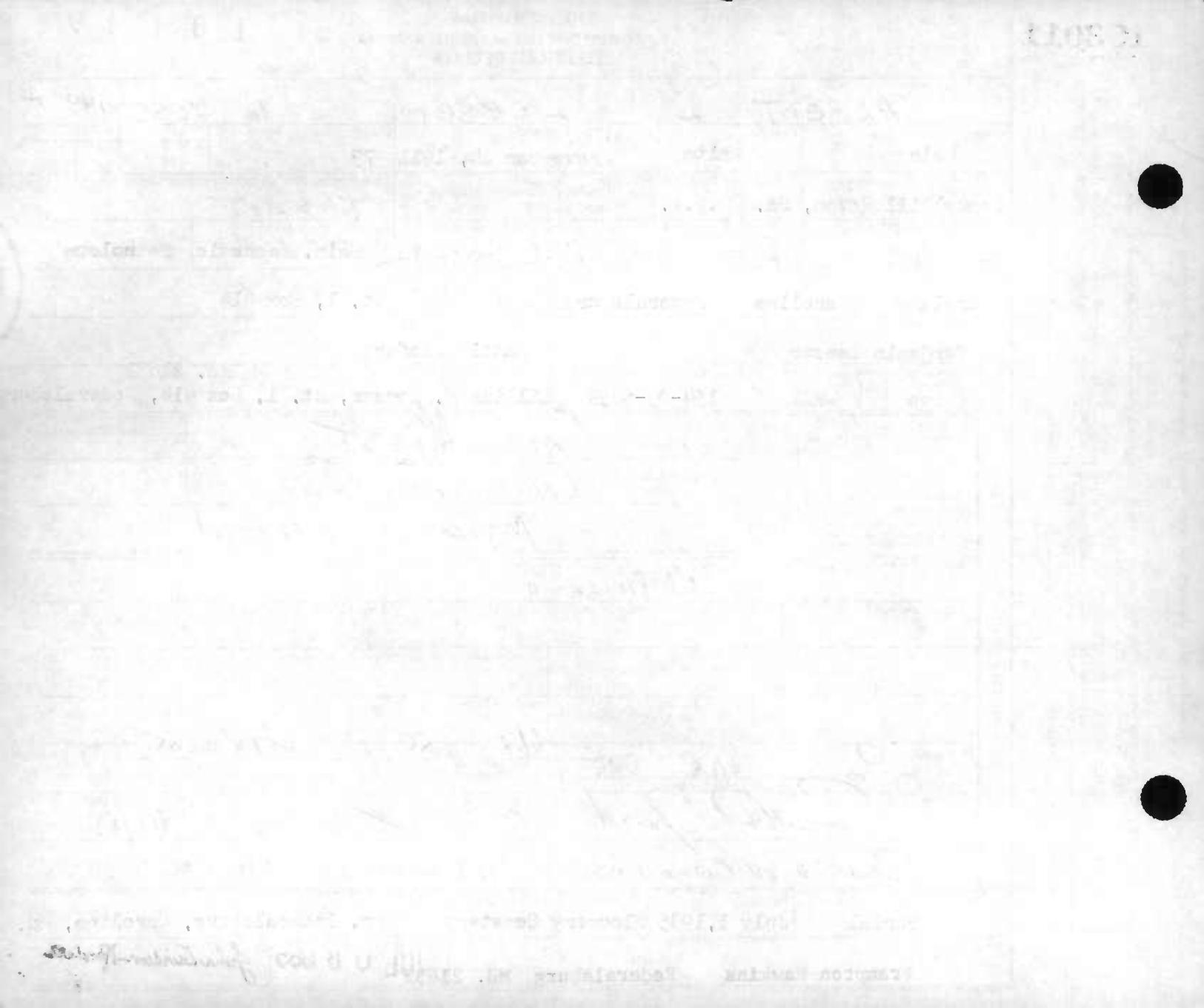
8 5 1 8 1 4 9

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
		ALBERT L		Leeser	6	28	85	940	A M	
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		White	MONTH DAY YEAR November 24, 1911		73	YRS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Schuylkill Haven, Pa.		U.S.A.				TALBOT				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
EASTON, MD		EASTON MEMORIAL HOSPITAL		Main. Mechanic		Petroleum				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland		Caroline	Federalsburg	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 414 21632				
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		Benjamin Leeser		Hattie Siefert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
Yes		WWII 154-03-5659		Lillian M. Leeser, Rt. 1, Box 414, Federalsburg		Md. 21632				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiac Shock</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Emphysema</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on <i>6/8 85</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (I) did not view the body after death.				6/8 85		6/28 85				
22b. SIGNATURE <i>Scott D. Friedman, MD</i>		DEGREE				22c. DATE SIGNED <i>7/1/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Scott D. Friedman, MD		403 Marvel Cr. Easton, MD 21601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		July 1, 1985	Bloomery Cemetery		Rt. Federalsburg, Caroline, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 0 1985		25b. REGISTRAR'S SIGNATURE <i>Juha Lassila-Pendell</i>				
Frampton-Hawkins		Federalsburg, Md. 21632								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/Death permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, it is medical examiner must be notified at once.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

## REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 1 8 1 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT): <b>Doris</b>				FIRST: <b>DORIS</b>	MIDDLE: <b>MELVIN</b>	LAST: <b>MATTHEWS</b>	2a. DATE OF DEATH: <b>June 27, 1985</b>	MONTH: <b>JUN</b>	DAY: <b>27</b>	YEAR: <b>1985</b>	2b. HOUR: <b>1 PM</b>			
3. SEX: <b>FEMALE</b>		4. RACE: <b>WHITE</b>		5. DATE OF BIRTH: <b>12- 26- 33</b>			6. AGE (IN YEARS LAST BIRTHDAY): <b>51</b>			IF UNDER 1 YEAR MONTHS: <b>0</b> DAYS: <b>0</b>		IF UNDER 24 HRS HOURS: <b>0</b> MIN: <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY?: <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH: <b>TALBOT MD.</b>							
10. CITY OR TOWN OF DEATH: <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): <b>MEMORIAL AT EASTON, MD. INC.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): <b>clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY: <b>Jewelry</b>							
13a. STATE: <b>Maryland</b>		13b. COUNTY: <b>Dorchester</b>		13c. CITY OR TOWN: <b>Cambridge</b>			13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			13e. STREET ADDRESS / ZIP CODE: <b>21613 209 Oakley St., Cambridge, Md.</b>				
14. FATHER'S NAME FIRST: <b>ROY</b>		MIDDLE: <b>S.</b>		LAST: <b>MELVIN</b>			15. MOTHER'S MAIDEN NAME: <b>LOUISE</b>			MIDDLE: <b></b>			LAST: <b>TODD</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>		16b. SOCIAL SECURITY NO.: <b>214-30-8658</b>		16c. ADDRESS: <b></b>			17. INFORMANT: <b>husband</b>			ADDRESS: <b>RICHARD M. MATTHEWS, same as 13e</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute and Massive</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b></b>		
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intra Cardiac Hemorrhage</b>														
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <b>6-25</b> MONTH <b>1985</b> DAY <b>19</b> YEAR <b>1985</b> P.M. <b></b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET: <b></b>			CITY OR TOWN: <b></b>		COUNTY: <b></b>		STATE: <b></b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>6-25</b> , 19 <b>85</b> , to <b>6-27</b> , 19 <b>85</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>6-27</b> , 19 <b>85</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did (did not) see the body after death.														
22b. SIGNATURE: <b>Acute</b>		22c. DEGREE: <b></b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED: <b></b>						
22f. PHYSICIAN'S NAME (TYPE OR PRINT): <b></b>		22g. ADDRESS: <b></b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): <b>burial</b>		23b. DATE: <b>6/30/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS: <b>Dorchester Mem. Pk.</b>			23d. LOCATION: <b>Airey, Cambridge, Dor., Md.</b>		23e. COUNTY: <b></b>		23f. STATE: <b></b>			
24. FUNERAL DIRECTOR NAME: <b>Curran Funeral Home, 21613</b>		ADDRESS: <b>308 High St., Cambridge, Mu.</b>		25a. DATE REC'D. BY REGISTRAR: <b>JUL 03 1985</b>			25b. REGISTRAR'S SIGNATURE: <b>John Curran</b>							

660284

169034

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1a. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18151

REG. NO.

1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI. DEATH MATED												2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			MONTH	DAY	YEAR	2b. HOUR					
Laura Elizabeth McVay												6	6	85	40					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY			7. IF UNDER 1 YR.			8. UNDER 24 HRS.			2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR				
F	W	NOV. 6 1907	77 yrs.			MONTHS DAYS			HOURS MIN			6/6	19	85	40					
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH								
III.			USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>			Talbot								
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial Hosp. @ Easton												SALES PERSON / SALESMAN / HOME					
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			14. STATE			15. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
			MD			CAROLINE			DENTON			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			205 KERR AVE. 21629					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
GEORGE			Sweetbourn			FAYE			323 46 7293			YES BARBARA GILLEN, DENTON, MD 21629								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			16c. (b) DUE TO, OR AS A CONSEQUENCE OF			16d. (c)			16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
NO																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?					
															YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>																	
ACTUAL SIGNATURE R. Lane Wroth, M.D.			TITLE M.D.			NIGHT			MEDICAL EXAMINER											
EXAMINER'S NAME (TYPE OR PRINT)																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL DELMARVA CEMETERY			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE					
CREMATION			JUNE 7, 1985									SUSSEX			DE.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
MOORE FUNERAL HOME			DENTON MD			JUN 10 1985			Julia Davidson-Pendell											
20M 4/82																				

卷之三

184020

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 18152

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST James MIDDLE Henry LAST MELVIN James	2a DATE OF DEATH MONTH DAY YEAR	2b. HOUR			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
Male			White	July	9, 1907	77		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA	NEVER MARRIED DIVORCED		Talbot		
10. CITY OR TOWN OF DEATH			NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION NOT IN SUCH FACILITY, GIVE STREET ADDRESS			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Easton			Hospital EASTON MEMORIAL			Mechanic(ret.)		
13a. STATE 13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Maryland			QueenAnne's			13e. STREET ADDRESS / ZIP CODE Del Rhodes Ave., P.O. Box 196 21658		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Charles Manship Melvin			Annie Elizabeth Hessey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT Wife ADDRESS Mrs. Jeannette S. Melvin, Queenstown, Md. 21658		
Yes WW II			218-05-9067					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION								
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1 JAN 1985</u> to <u>19 JUN 1985</u> , that (I) (we) lost saw the deceased alive on <u>19 JUN 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do not) (did not) view the body after death.								
22b. SIGNATURE <i>Stephen P. Carney</i>			DEGREE			22c. DATE SIGNED 6/19/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.			22e. ADDRESS Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 21, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cemetery		
24. FUNERAL DIRECTOR NAME James H. Barton, Jr. Barton Funeral Home			ADDRESS Centreville, Md. 21617			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Julia Davidson-Bardes		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, if medical examination is required, it should be done within 24 hours of the death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Form 4 may be

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT) If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

165071

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5

18153

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Gilma			E.	Mueller		6	9	85	11:05 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
female		caucasian		MONTH	DAY	YEAR	60	YRS	MONTHS	MONTHS	YEARS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED	
Maryland		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.			
Easton		Memorial Hospital		Seamstress		Clothing					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13e. STREET ADDRESS / ZIP CODE								
Maryland	Talbot	Easton	809 Applewood Court/21601								
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	ADDRESS			
Merrell		H.	Evans Sr.	Margaret		A.	Jackson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		218-16-8901		F. Vernon Mueller		see 13e. 7 years					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)						DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF					
(b)											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				21c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
		P.M.		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22c. THE PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS				22e. DATE SIGNED					
Lawrence D. Bohan		Dutchman's Lane, Easton, Md.				6-9-85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		6-12-85		Spring Hill Cemetery		Easton		Talbot		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Newnam Funeral Home		Easton, Md.		JUN 12 1985		Anne Newnam - Bohan					

150604



184117

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 | 8 | 5 | 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
Louise Beauchamp Mueller			June 22 85			6:35 AM					
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
Female		Caucasian	MONTH	DAY	YEAR	75	YRS	IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U. S. A.						Talbot			
10. CITY OR TOWN OF DEATH		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital			Teacher			Education			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Caroline		Denton					21629 Beauchamp Branch Road		
14. FATHER'S NAME		FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME			LAST		
Herbert				Beauchamp		Corinne			Thawley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		218422525		Mr. Charles B. Todd, Preston, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.											
DUE TO, OR AS A CONSEQUENCE OF (c) Scleroderma											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Renal Failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?			19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					<input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 19 PART 1 (OR PART 2)						
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (b) (this hospital) attended the deceased from now the deceased died on 6/24/85 1985 to 6/22 1985 that (b) (we) last saw the deceased alive on 6/24/85 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did not view the body after death.											
22b. SIGNATURE Wm H. Wood		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 6/24/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H. Wood		22e. ADDRESS EASTON, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/26/85		23c. NAME OF CEMETERY OR CREMATORIAL Concord Cemetery			23d. LOCATION CITY OR TOWN Denton Caroline, Md			COUNTY STATE	
24. FUNERAL DIRECTOR NAME Audrey P. Deacon		ADDRESS Deacon, Denton, Md.			25a. DATE RECEIVED BY REGISTRAR JUN 27 1985			25b. REGISTRAR'S SIGNATURE Audrey P. Deacon			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon portion. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be

169036

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 1 8 1 5 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Leviel Clark Murphy						MAY	31	85	3:50 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Male		White		MONTH	DAY	YEAR	72		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		USA							Talbot		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton		Memorial Hospital				Farmer			Farm		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Caroline		Ridgely		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			207 Maple Ave. 21660		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
		John	G.	Murphy	Iva			Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No		218 34 9461		Mary Murphy			Ridgely, MD 21660				
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarct</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe atherosclerosis</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe atherosclerosis</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Hypertension</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> <u>1978</u> to <u>5-31</u> <u>1985</u> , that (I) (we) last saw the deceased alive on <u>19</u> <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>T.P. Detrich, M.D.</i> DEGREE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED			
T.P. Detrich, M.D.		Easton, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		6-4-85		Greensboro Cemetery			Greensboro		CA	MD	
24. FUNERAL DIRECTOR NAME <i>John E. Boulais</i> ADDRESS <i>Greensboro, MD 21639</i>											
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
JUN 10 1985		<i>John E. Boulais</i>									

80021

polymerized

today

length vacuum heated

1

length

169069

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 1 8 1 5 6

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21. HOUR		
WILLIAM DOVE NOBLE						6	11	85	11:00 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
male		caucasian		MONTH 8	DAY 4	YEAR 1891	93	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		USA				Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Easton		701 Elwood Avenue, Easton		Physician		Medicine						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13e. STREET ADDRESS / ZIP CODE 701 Elwood Ave./21601						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Jacob		L.		Noble		Manie		Eugenia		Travers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
Yes			W W I			220-44-3491			Anne N. Bradley Rose Valley, Pa. 19060			
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Congestive Heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER))		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (themselves) attended the deceased from 6-29, 19 73, to 6-11, 19 85, that (I) (we) last saw the deceased alive on 6-11, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Stephen P. Carney		DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
Stephen P. Carney, M.D.		Dutchman's Lane, Easton, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
cremation		6-11-85		Salisbury Crematory		Salisbury		Wic.		Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Newnam Funeral Home		Easton, Md.		JUN 14 1985								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

60021



DO GOLDEN EGG

171038

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 1 8 1 5 7

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Carolyn					OREM	5	29	85	12:01 P			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			Cauc	3	18	1910	75					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
MD			USA						TALBOT			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
EASTON			MEMORIAL HOSPITAL			MD Q. A. Sudlersville			Secretary			
13. STATE			13a. COUNTY			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE			
MD			Q. A.			Sudlersville			Rt 1 Box 59 21668			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Charles H. Melville						Anna K Schmidt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
N/A			220-01-5967			Anna Campbell			Acute renal failure, acidosis? cause 4 day			
19. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			20. DUE TO, OR AS A CONSEQUENCE OF (b)									
			(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED					21a. AUTOPSY?		21b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
		P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on <u>5/29</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.					5/29 19 85		5/29 19 85					
22b. SIGNATURE					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Lynn B. Congdon									6-3-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
6-1-85		6-1-85		Chester			Chesterstown		Kent	MD		
24. FUNERAL DIRECTOR NAME		ADDRESS			Midnight		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Fellows Funeral Home		Box 270 MD			JUN 11 1985							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Funeral Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner should be notified.

卷之三

189074

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 -  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
SARAH P. PALLER						6-27-85				8:45 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7b. HOUR	
Female		caucasian		MONTH	9	DAY	26	YEAR	90	IF UNDER 1 YEAR MONTHS	IF UNDER 1 HR HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Indiana		USA					Talbot				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Easton		William Hill Health Care Center		Musician			Music				
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE				
Maryland		Talbot		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			501 E. Dutchman's Lane/21601				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	
		Frederick	M.	Possell				Margaret	Sarah	Beier	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		132-09-0126		Sallie P. Tennant			4-26-85				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right femoral artery embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stopping the underlying cause lost (b) <u>arterial embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atrial fibrillation</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Congestive heart failure</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 21)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>1-9</u> , 19 <u>84</u> , to <u>6-27</u> , 19 <u>85</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>6-27</u> , 19 <u>85</u> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
Robert W. Trever, M.D.								6-28-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Robert W. Trever, M.D.		RD3 Box 297 Easton, Md. 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION				
Burial		7-1-85		Oxford Cemetery			CITY OR TOWN Oxford			COUNTY Talbot	STATE Md.
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home		Easton, Md.			JUL 02 1985			John Newnam			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25000



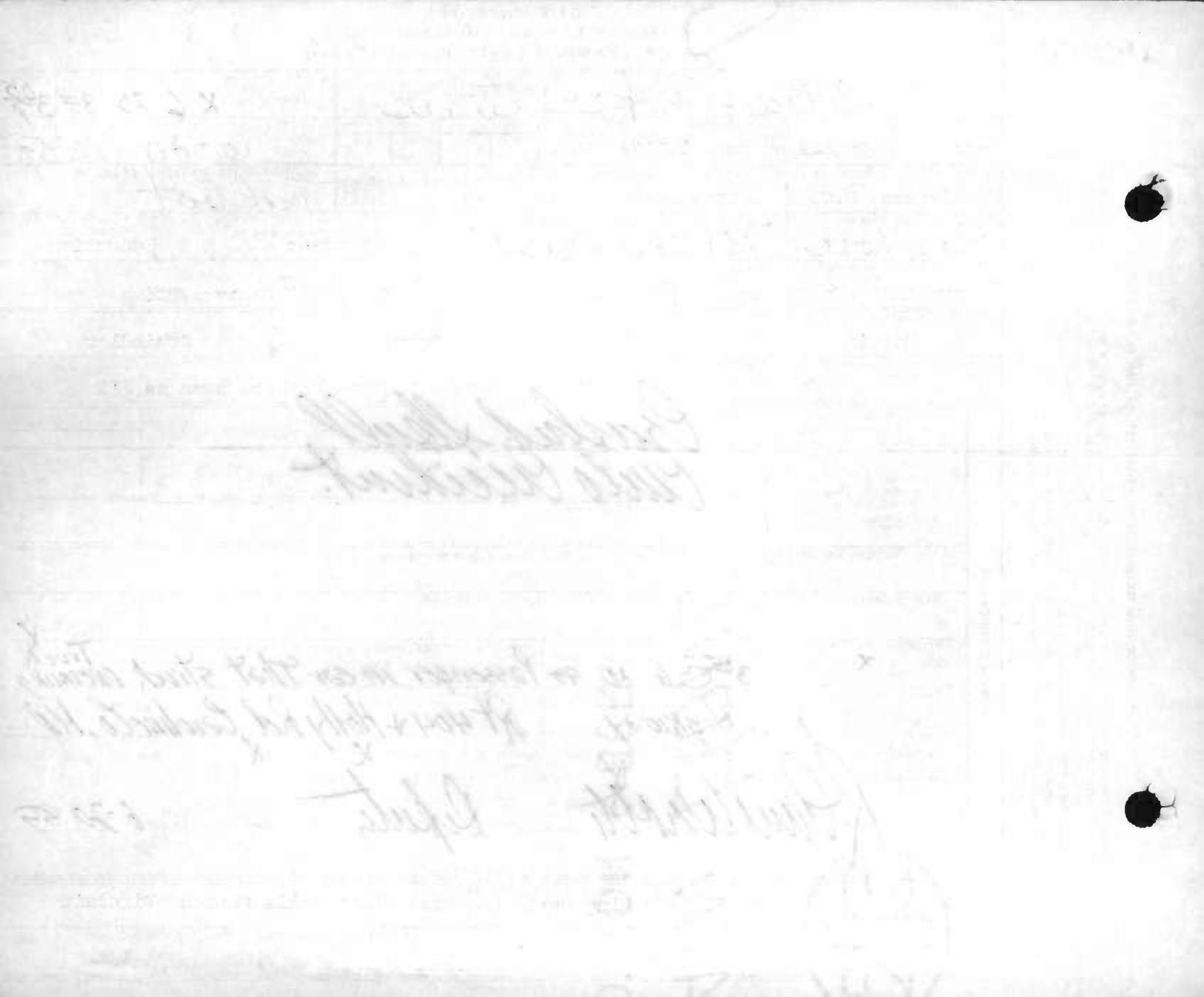
3

182035

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. SIGN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PAGES 1 AND 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 18159											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MICHAEL			MIDDLE D. Perlman			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR							
1. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH Oct.			6. AGE (IN YEARS) YEAR 1974 LAST BIRTHDAY 10 YRS.			IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	MONTH	DAY	YEAR	2d. HOUR					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot			10. DATE PRONOUNCED DEAD 6-20 1985			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial			12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE Student			12b. KIND OF BUSINESS OR INDUSTRY Education		
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Potomac			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 11611 LeHavre Drive			20834								
14. FATHER'S NAME FIRST Marvin			MIDDLE			LAST Perlman			15. MOTHER'S MAIDEN NAME Dorothy			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Marvin Perlman Father, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 8121			IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) starting the under- lying cause last.			(b) DUE TO, OR AS A CONSEQUENCE OF			(c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:05 6 20 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in car that struck, crashing Truck																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY 1 AT HOME, STREET FACTORY FARM, ETC.) Highway			21f. LOCATION STREET AT 404 Holly Rd, Larchmont, MD CITY OR TOWN COUNTY STATE																	
22a. I certify that I, the owner of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																				
ACTUAL SIGNATURE R. Paul W. Perlman			M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT) Burial			ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 23, 1985			23c. NAME OF CEMETERY OR CREMATORIAL King David Memorial Pk., Falls Church, Virginia			23d. LOCATION CITY OR TOWN Falls Church, Virginia COUNTY STATE								
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Falls Church, Va. 22046			25a. DATE REC'D. BY REGISTRAR JUN 27 1985			25b. REGISTRAR'S SIGNATURE John Randolph																	
DHMH - 17 (VR A15 ME (5)) 20M 4/82																							



Lecter date left  
11.11.1911

170130

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 18160

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>PERCY</i>	MIDDLE <i>Y</i>	LAST <i>POLLARD</i>	20. DATE OF DEATH MONTH <i>June</i>	DAY <i>8</i>	YEAR <i>1985</i>	2b HOUR <i>8:00 A.M.</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>June</i>		DAY <i>8</i>	YEAR <i>1985</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>65</i>		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY <i>USA Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>TALBOT</i>			
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HOSPITAL, GIVE STREET ADDRESS) <i>MEMORIAL HOSPITAL EASTON</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cutter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Timber</i>		13. STREET ADDRESS / ZIP CODE <i>21632 old Denton Rd. Fed., Md.</i>			
13. STATE <i>Maryland</i>		14. COUNTY <i>Caroline</i>		14a. CITY OR TOWN <i>Federalburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Fed., Md. 21632</i>			
15. FATHER'S NAME FIRST <i>Samuel</i>		MIDDLE <i></i>	LAST <i>Pollard</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Lucy</i>		MIDDLE <i></i>	LAST <i>Dailey</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO <i>N/A 213-12-5328</i>		17. INFORMANT <i>Percy Pollard, Jr.</i>		ADDRESS <i>Old Denton Road</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Cardiorespiratory arrest*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHConditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause (b).(b) *hypoxia, hypercarbia*DUE TO, OR AS A CONSEQUENCE OF  
(c) *severe COPD, CHF, MI*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	---	---

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
---	--	---

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
---	--	-------------------------	--------------	--------	-------

22a. I certify that (I) (this hospital) attended the deceased from *5-19*, 19 *85*, to *6-8*, 19 *85*, that (I) (we) last  
saw the deceased alive on *6-7*, 19 *85*, and that in (my)  opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did)  (did not)  view the body after death.

22b. SIGNATURE <i>Robert B. Sanchez</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>6-8-85</i>
--	---------------------	--	-----------------------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert B. Sanchez</i>	22e. ADDRESS <i>322 Commerce Dr. EASTON MD</i>
---	---

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>6-11-85</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bloomery</i>	23d. LOCATION CITY OR TOWN <i>Federals.</i>	COUNTY <i>Caroline</i>	STATE <i>Md.</i>
---	-----------------------------	---	---	---------------------------	---------------------

24. FUNERAL DIRECTOR NAME <i>Harold Williamson</i>	ADDRESS <i>Federalburg, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>JUN 13 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Robert B. Sanchez</i>
--	------------------------------------	---	--

TA0130

170131

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 1 6 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be given to the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the physician from whom the information came should be notified at once.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
William F. Rebstock								6 - 8			-85	3 55
3. SEX	Male	4. RACE	Cau.	5. DATE OF BIRTH		MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 12 HRS HOURS MIN.
				Oct. 27 1900					84			
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Germany		USA						Talbot				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR PRINT, IF OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Easton		Delmarva		retired		Farmer						
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Laurel Grove Rd. 21632				
FATHER'S NAME Fritz		MIDDLE Rebstock		15. MOTHER'S MAIDEN NAME Caroline		LAST Maurer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 119-10-5944		17. INFORMANT Linda Rollman		ADDRESS Easton Md.						
no												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		COPD, RESPIRATORY ARREST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any		Myocardial Infarction						10/17				
(b)												
(c)		Coronary Disease						MOS.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (was hospital) attended the deceased from saw the deceased alive on 6/8 1985 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				6/1 85		6/8 85						
22b. SIGNATURE Scott D. Friedman, MD		DEGREE		22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 6/8/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Scott D. Friedman		22e. ADDRESS 403 Marvel Ct Easton, MD 21601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6-9-85		23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory		23d. LOCATION Lewis Sussex		COUNTY		STATE Del.		
24. FUNERAL DIRECTOR NAME WILLIAMSON F. H. FEDERALSBOURG, MD.		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 13 1985		25b. REGISTRAR'S SIGNATURE John Williamson - F. H. F.						

remove

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18162  
REG. NO.

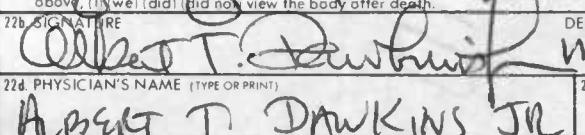
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR		
CHARLES EDWIN ROTH						<input checked="" type="checkbox"/>	6	1	1985	1145		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
male	caucasian	7 18 35	49 yrs.			-						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA					TALBOT					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
EASTON		MEMORIAL HOSPITAL			Maintenance worker		Shipyard					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Talbot		Oxford		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		202 Tred Avon Ave./Oxford				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST				
Charles		William		Roth		Evelyn G.		Sullivan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES		218-30-1948		Doris M. Roth		see 13e.		months				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		23a. EXAMINER'S NAME (TYPE OR PRINT)			TITLE (SPECIFY) M.D. <i>swd.</i>		MEDICAL EXAMINER				DATE SIGNED <i>6-1-85</i>	
<i>Louis S. Welty</i>		<i>Louis S. Welty</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		6-5-85		Oxford Cemetery			Oxford		Talbot		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Newnam Funeral Home		Easton, Md.		JUN 5 1985		<i>John Pendell</i>						

1

RECORDED

165089

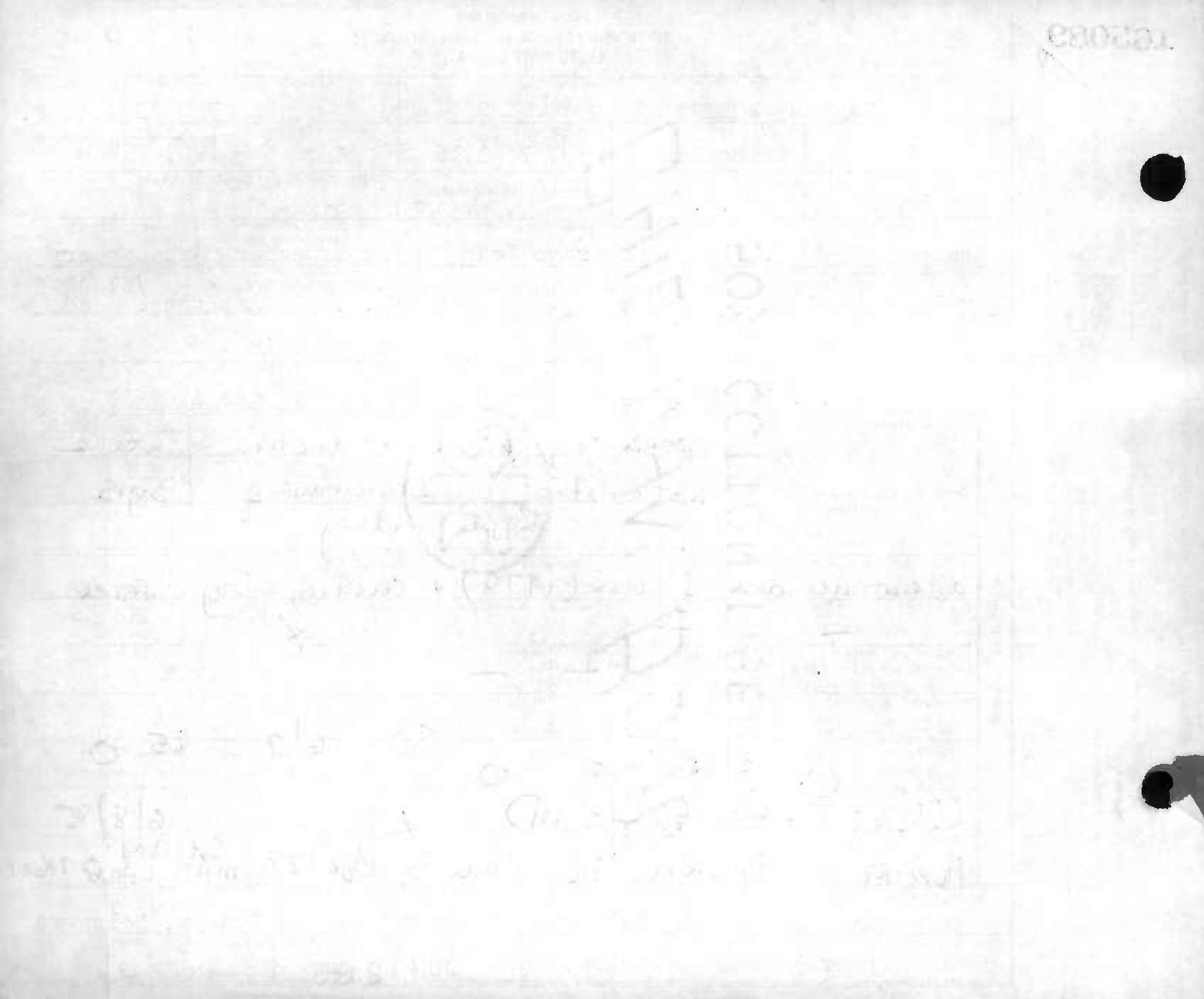
1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8 5 1 8 1 6 3  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
CHARLES ROBERT					ROWENS	6	7	85	4:42 P.				
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		caucasian	Mar. 7, 1916			69	YEARS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.							Talbot MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton		R.D. #1, Anchorage Road			storekeeper			stationery					
13a. STATE Maryland						13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE R.D. #1, Anchorage Road /21601	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME Elizabeth Hardin							
Elwood		Rowens											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		ADDRESS							
Yes		W.W. 11 212-18-6798		Betty G. Rowens		See item 13							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b1, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks							
respiratory failure + anemia													
DUE TO, OR AS A CONSEQUENCE OF (b) metastatic adenocarcinoma of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.						3 yrs.							
DUE TO, OR AS A CONSEQUENCE OF (c) Right Kidney													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a adenocarcinoma of colon (1978) + coronary artery disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
—		—				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
—		P.M. 19		—									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
—		—		—		—		—		—			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/25 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) did not view the body after death.						19 80 to 6 12 85, that (I) (we) last							
22b. SIGNATURE 						22c. DATE SIGNED 6/8/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Albert T. Drownkins Jr.		Route 3, Box 127				EASTON MARYLAND 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY STATE			
Cremation		6-8-1985		Delmarva Crematory		Lewes, Sussex, Delaware							
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR JUN 12 1985							
Newnam Funeral Home						25b. REGISTRAR'S SIGNATURE 							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



184012

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 1 8 1 6 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Viora Edith Russell						06	16	85	6:45 P M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		July 29, 1892		92		YRS		MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Reliance, Md.		U.S.A.				Talbot					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Easton		The Meridian Nursing Center		Housewife		Own Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21632	
Maryland		Dorchester		Federalsburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 189			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Stephen Thomas Waller						Edith May Bryan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		Maryland 21632			
No		215-36-0865		A. Welton Russell, Adams Rd., Federalsburg,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <10 minutes					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						Coronary thrombosis					
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary thrombosis						Uncertain					
(c) arteriosclerotic heart disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Alzheimer's disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) (they) attended the deceased from 5-13, 1968, to 6-16, 1985, that (I) (we) (they) saw the deceased alive on 6-16, 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Robert W. Trever, M. D.								6-17-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				RD 3 Box 297 Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		June 20, 1985		Hillcrest Cemetery Box 43		Federalsburg, Caroline, Md.					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Flemington - Hawkins											
FEDERALSBURG, MD. JUN 24 1985											

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician, it should be detached from the burial permit. Then please remove carbon paper from the back of the form and file with the burial permit with the State Dept. of Health and Mental Hygiene prior to burial.   
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

210181

163024

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 8 5 1 8 1 6 5

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Nora</i>	MIDDLE <i>Virginia</i>	LAST <i>Sewell</i>	2a. DATE OF DEATH MONTH DAY YEAR 6 4 1890	MONTH 6	DAY 4	YEAR 85	2b. HOUR 7:35 p.m.		
3. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 4 1890	6. AGE IN YEARS LAST BIRTHDAY 95		7. IF UNDER 1 YEAR MONTHS YRS		8. IF UNDER 14 MRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot County</i>				MD.	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Easton Memorial</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>107 Brookletts Ave/21601</i>			
14. FATHER'S NAME FIRST <i>William</i>		MIDDLE <i>Edward</i>		LAST <i>Jackson</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Lydia</i>		MIDDLE <i>Ann</i>		LAST <i>Anthony</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. <i>213-01-8199</i>		16c. INFORMANT <i>Jackson Sewell</i>		16d. ADDRESS <i>611 Elwood Ave. Easton, Md. 21601</i>		16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).  (b)  DUE TO, OR AS A CONSEQUENCE OF (c)  Pneumonia old age											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <i>6-4</i>		CITY OR TOWN <i>Easton</i>		COUNTY <i>Talbot</i>		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-4-85</i> to <i>6-7-85</i> , 19, to <i>6-7-85</i> , 19, that (we) last saw the deceased alive on <i>6-4-85</i> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>Thomas W. Fauntleroy, Jr.</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>6-7-85</i>					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas W. Fauntleroy, Jr.</i>		22g. ADDRESS <i>Easton, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-7-85		23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery		23d. LOCATION CITY OR TOWN Easton		COUNTY Talbot		STATE Md.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		25a. DATE REC'D. BY REGISTRAR JUN 10 1985		25b. REGISTRAR'S SIGNATURE							
ADDRESS Easton, Md.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial/transit permit. Then please remove carbon copies. Pages 1, 2, and 3 may be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is checked, attach a statement of injury, or other traumatic event, the medical examiner should be notified.

163034

to south of the note 3



1S3008

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 1 8 1 6 6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper, pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one:

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Grace J Shorts						June 26 1985	10 <sup>7</sup>			AM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS		
Female	White	MONTH	DAY	YEAR	50	MONTHS	DAYS	HOURS	MIN.		
10 <sup>7</sup>	10	11	34		YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA				Talbot						
MD.											
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY
Easton	Memorial Hospital					Homemaker					Home
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland	Caroline	Greensboro				Knife Box Road					21639
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE					
Franklin		Johnson	Lillian			Hamilton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS						
no	214 32 0556	William R. Shorts, Sr.			Greensboro, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung Lung</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 mo
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-8 19 84 to 6-26 19 85, that (I) (we) last saw the deceased alive on 6-26 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Stephen P. Carney, M.D.									6-28-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Stephen P. Carney, M.D.			Easton, MD 21601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN	COUNTY			STATE		
Burial	6-28-85	Concord Cemetery			Federalsburg	CA			MD		
24. FUNERAL DIRECTOR NAME	ADDRESS			25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE		
John E. Boulais	Greensboro, MD			JUL 08 1985					John E. Boulais		

Country of India

Government of India, Ministry of External Affairs

U.S. Post

177113

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 18167

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES ADAM BUCHANAN SHREVE</b>			2a. DATE OF DEATH <b>6 19 85</b>	MONTH YEAR	DAY	2b. HOUR <b>140 PM</b>
3. SEX <b>male</b>	4. RACE <b>caucasian</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>26</b> YEAR <b>1891</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	7. IF UNDER 1 YEAR MONTHS <b>0</b>	8. IF UNDER 24 HRS DAYS <b>0</b>	9. IF UNDER 4 HRS HOURS <b>0</b>
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	11. CITIZEN OF WHAT COUNTRY? <b>USA</b>	12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	13. CITY OR TOWN OF DEATH <b>Easton</b>	14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 5 Box 744, Easton, Md.</b>	15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Broker</b>	16. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>
17. STATE <b>Maryland</b>	18. COUNTY <b>Talbot</b>	19. CITY OR TOWN <b>Easton</b>	20. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21. STREET ADDRESS / ZIP CODE <b>Rt. 5 Box 744, Easton, Md. 21601</b>		
22. FATHER'S NAME FIRST <b>Oswald</b>	MIDDLE <b>Tilghman</b>	LAST <b>Shreve</b>	23. MOTHER'S MAIDEN NAME FIRST <b>Ann</b>	MIDDLE <b>Lux</b>	LAST <b>Buchanan</b>	24. ADDRESS
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) <b>Yes</b>	26. IF YES, GIVE WAR OR DATES <b>W W I</b>	27. SOCIAL SECURITY NO. <b>216-09-0835</b>	28. INFORMANT <b>Corinne S. Shreve see 13e.</b>	29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL GASTROINTESTINAL CARCINOMA</b>						
31. DUE TO, OR AS A CONSEQUENCE OF (b) _____ 32. DUE TO, OR AS A CONSEQUENCE OF (c) _____						
33. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>RENAL FAILURE</b>						
34. MEDICAL CERTIFICATION	35. DATE OF OPERATION	36. CONDITION FOR WHICH OPERATION WAS PERFORMED	37. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	38. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
	39. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	40. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	41. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
	42. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	43. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	44. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	45. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on <b>6/18 1985</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.	46. DEGREE <b>MD</b>	47. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	48. DATE SIGNED <b>6/19/85</b>		
	49. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm. BREMER</b>	50. ADDRESS <b>ST. MICHAELS MD 21663</b>				
	51. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	52. DATE <b>6-21-85</b>	53. NAME OF CEMETERY OR CREMATORIAL <b>Sherwood Epis. Church Cem. Cockeysville</b>	54. LOCATION CITY OR TOWN <b>Cockeysville</b>	55. COUNTY	56. STATE <b>Md.</b>
	57. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home, P.A.</b>	58. ADDRESS <b>Easton, Md.</b>	59. DATE REC'D. BY REGISTRAR <b>JUN 24 1985</b>	60. REGISTRAR'S SIGNATURE <b>Jeanne Garrison Pendell</b>		

CLASS



184024

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified or a doctor must be notified of any death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5	1	8	1	6	8	
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Lee			J.			Smith			Sr.			June 15 85		25	4	PM	4 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male			White			2 MONTH 16 DAY 1901			84			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot			Antiques						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY									
Easton			Memorial Hospital			Dealer			21632									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME						
Maryland			Caroline			Federalsburg			Samuel			Molly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			213-01-83074			Oxford, Md. 21654			Ventricular fibrillation			<10 min.						
Mr. Lee Smith, Jr. Tilghman St.																		
18c. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease			19c. DUE TO, OR AS A CONSEQUENCE OF (c) Uncertain															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.												20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			20a. IF YES YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF NO YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET			21j. CITY OR TOWN			COUNTY		STATE				
22a. I certify that (1) (this hospital) attended the deceased from 2-1, 1983, to 6-15, 1985, that (1) (we) last saw the deceased alive on 6-15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.												22c. DATE SIGNED 6-15-85						
22b. SIGNATURE Robert W. Trever, M.D.			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trever, M.D.			22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 6-18-85			23c. NAME OF CEMETERY OR CREMATORIAL Jr. Order Cemetery			23d. LOCATION CITY OR TOWN Preston Caroline Maryland			25a. DATE REC'D. BY REGISTRAR JUN 24 1985						
24. FUNERAL DIRECTOR NAME Williamson Funeral Home			ADDRESS Federalsburg, Md. 21632									25b. REGISTRAR'S SIGNATURE Julie Swanson Pendleton						

Booper's W. Tripper, M.D.,  
R.D. 3, Box 300, Lapeer, MI 48446

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and should be consulted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
16168051 F												85 18169				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
Elizabeth			Streeter			6-6 -85			2:40 PM							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		2b. HOUR HOURS MIN.				
Female		Black		May 21 1932			53			YRS.		2b. HOUR HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Md.		45					Talbot									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Easton		Tidewater					Laborer									
13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 617 High St. 21613						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
William Cornish		Vera Cornish														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS												
		217-28-3611		Charles Streeten			Crab									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast cancer</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs				
DUE TO, OR AS A CONSEQUENCE OF (b) _____																
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 19 83</u> to <u>Jun 6 85</u> , that (I) (not) lost soul the deceased alive on <u>Jun 6 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (not) (did not) view the body after death.																
22b. SIGNATURE <u>Stephen P. Carney</u>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS Easton, Md. 21601			22e. DATED SIGNED 6/7/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																
Stephen P. Carney, M.D.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 6/10/85		23c. NAME OF CEMETERY OR CREMATORIAL Taxes Ceme.			23d. LOCATION City or Town Tidewater Dorchester Md.			23e. COUNTY STATE						
24. FUNERAL DIRECTOR NAME		ADDRESS Stewart Funeral Home Salisbury Md.			25a. DATE REC'D. BY REGISTRAR JUN 12 1985			25b. REGISTRAR'S SIGNATURE G. Stewart								

12000  
7

100%  
COTTON

100% COTTON

100% COTTON

100% COTTON

100% COTTON

171035

Page 4 may be

reduced

or enlarged

when copied

or photocopied

or otherwise

altered

or otherwise

changed

or otherwise

altered

or otherwise

altered

or otherwise

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be completed.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 18170

REG. NO.

1- FOR STATE REGISTRAR	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
1 DECEASED NAME (TYPE OR PRINT)	Frederick GLEAVES USILTON SR.			DEC 20 1985				11 29 AM
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	73			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
11	WHITE	MONTH DAY	YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
MD	USA		Talbot					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Easton	Memoria Hospital			TEACHER			EDUCATION	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE				
MD	CAROLINE	DE. TOW.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	306 S. 2 <sup>nd</sup> 21629				
4. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	16. ADDRESS			
FREDERICK	GLEAVES		USILTON SR.	ADDIE	PATIENCE P. USILTON DE. TOW., MD.			HURLOCK
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	16c. INFORMANT	17. ADDRESS					
NO	219 36 6365	PATIENCE P. USILTON	DE. TOW., MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Standstill</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent Myocardial Infarction</u> 1 week								
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> 7+								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Recent Pulmonary Embolus (7/30/85)</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/2 1985 to 6/6 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>W M H Wood</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22c. DATE SIGNED <u>6/3/85</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>Easton MD</u>					
W M H Wood								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION CITY OR TOWN	23e. COUNTY			23f. STATE
CREMATION		6/13/85	DELMAR CEMETARY	COWES	SUSSEX			DE.
24. FUNERAL DIRECTOR NAME <u>Moore Funeral Home</u> ADDRESS <u>De. TOW.</u> 25a. DATE REC'D. BY REGISTRAR <u>UN 11 1985</u> 25b. REG. NO.								
Moore Funeral Home De. TOW.								

.3005.

17

182108

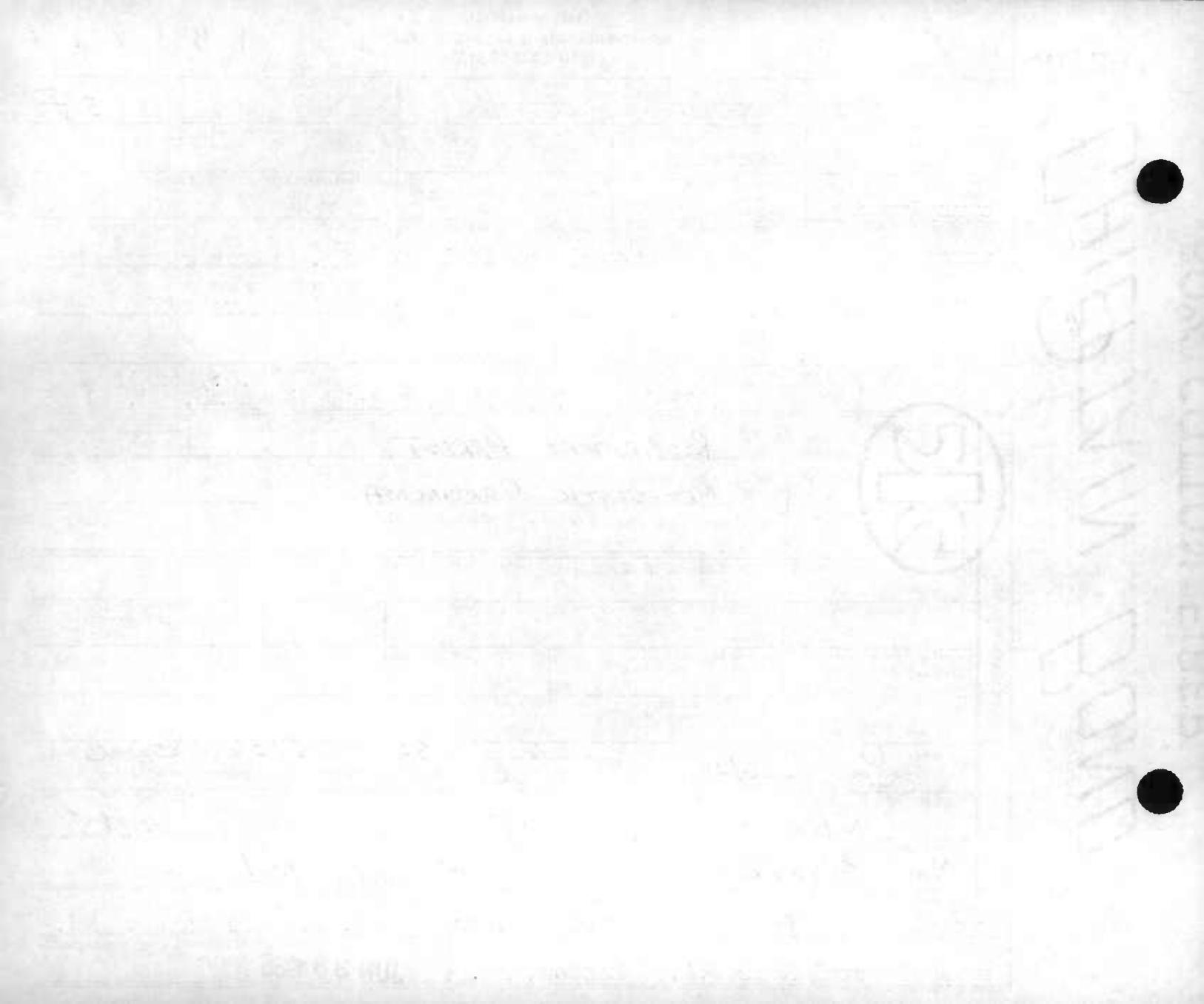
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. If it is not, it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use on the burial/transit permit. Then please remove carbon copy. Please sign and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of remains, or other unusual event, the medical examiner should be notified at once.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other unusual event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	21. HOUR										
LLOYD			VERNON			WARNER			6	26	85	5 05 P.M.											
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Male		caucasian		MONTH	DAY	YEAR	68	YRS.		MONTHS	DAYS	HOURS	MIN.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.													
Pennsylvania		USA					Talbot																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Easton		Easton Memorial Hospital										Equip. Operator		State Highway									
13a. STATE Maryland														13b. COUNTY Talbot		13c. CITY OR TOWN Newcomb			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Station Street/21653	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST		16. ADDRESS P.O. Box 13 Newcomb, Md. 21653														
Lewis		G.		Warner			Laura		Vernon														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
NO				218-10-2407			Edith V. Smith																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>																							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CARCINOMA</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c) _____																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>6</u> , 19 <u>82</u> , to <u>6/26</u> , 19 <u>85</u> , that (I) (we) lost sow the deceased alive on <u>6/26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.																							
22b. SIGNATURE <u>Wm BREMER</u>																							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>ST. MICHAELS MD</u>																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>Burial 6-28-85</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Olivet Cemetery</u>			23d. LOCATION CITY OR TOWN <u>St. Michaels Talbot Md.</u>			23e. COUNTY <u>Talbot</u>		STATE <u>Md.</u>									
24. FUNERAL DIRECTOR NAME <u>Newnam Funeral Home, P.A.</u>			ADDRESS <u>Easton, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>JUN 28 1985</u>			25b. REGISTRAR'S SIGNATURE <u>Jeanne D. Pendell</u>														



164103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3518172			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 9 <sup>05</sup> 9 AM				
Thomas C. Young						6-2-85							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
Male		Black		March 6, 1913			72			IF UNDER 24 HRS HOURS MIN.			
YRS													
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT			MD.		
Queen Anne Co., Md.		U.S.A.											
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL HOSPITAL						12a. USUAL OCCUPATION Laborer			12b. KIND OF BUSINESS OR INDUSTRY Funeral Home		
Maryland		Caroline			13c. CITY OR TOWN Preston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE P.O. Box 262 21655		
14. FATHER'S NAME Rhiney McDaniel								15. MOTHER'S MAIDEN NAME Mary McDaniel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-14-9134			17. INFORMANT Naomi Roberts, Box 515, Easton, Md. 21601			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerosis</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CVA													
19a. DATE OF OPERATION 5/22/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 522 1/2			21f. LOCATION STREET 1985 CITY OR TOWN 6/2 COUNTY 1985 STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>5/22/85</u> , 19 <u>85</u> , to <u>6/2</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>5/22/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE James C. Gieske		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 6/3/85					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Gieske MD		22g. ADDRESS Dutchman's Lane, Easton, Md. 21601											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 6, 1985			23c. NAME OF CEMETERY OR CREMATORIAL John's Cemetery			23d. LOCATION CITY OR TOWN Preston, Caroline, Maryland			23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME FRAMPTON - HAWKINS/FEDERALSBURG		ADDRESS BOX 43			25a. DATE REC'D. BY REGISTRAR JUN 11 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Rodgers					

1000 *W. C. COOPER*